

SEPTEMBER 1955

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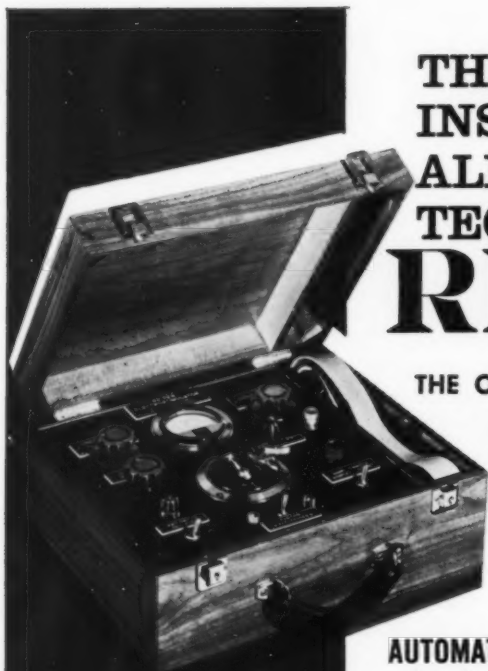
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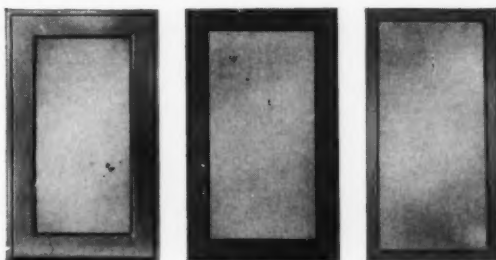
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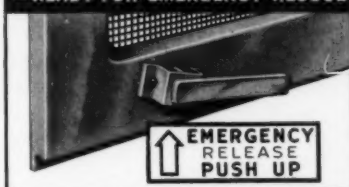
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Volume 6  
Number 9

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(Cover design by Henry D. Chaplin)

## THIS MONTH'S COVER

The picture shows an affiliate student nurse who has been assigned as the "special friend and companion" of a patient at St. Joseph Sanitarium, Dubuque, Iowa, for two weeks. Since the program was developed by the faculty, 212 such student nurses have taken an active part, in this way, in a patient's recovery.

Patient-nurse "teams" are selected by psychiatrists and nurse instructors, and the nurse student spends one or two hours each day with "her patient", taking part in hobbies or recreation which appeal to the patient. The nurse, after studying the patient's history and talking with him, is responsible for planning with assistance and approval from her instructor, the activities she and her patient will pursue.

The nurse has a half-hour conference with her instructor on the Friday of the first week, and additional conferences are held when necessary. At the end of the two weeks, she makes a written report, summarizing her experience with the patient. This report goes to the psychiatrist and is later placed with the patient's record. The student gives an oral report to faculty and other students at the end of the two weeks.

"Mrs. N's chief occupation, when I was first assigned to her, was staring at the designs on a green-flowered rug," wrote one student nurse of her patient. "I explained to her that my part was to help her enjoy hobbies and recreations of her own choice. I told her I was to be her special friend and that I would give her all the help I could towards recovery.

"She sat still, eyes on the intricate design of the rug. 'Let's the two of us go for a walk—it's such a beautiful day,' I suggested. The two of us started trudging along the flower-edged walks. I asked mild, impersonal questions which were answered only by clipped remarks, incomplete or incoherent.

"This went on for some days—walks, butterfly chasing, reviewing magazines, making a lampshade—but with little response from Mrs. N. Occasionally she said 'Thank you'—about the extent of her participation.

"But on the seventh day, my prayers were answered. I suggested a shampoo, as her husband was visiting her on the Sunday. Mrs. N. suddenly said 'I suppose I do look like I could stand it. Could you set it for me too?' The following day she asked if she could press her dress and put on some make-up. 'I certainly have neglected myself,' she said. 'I wonder what Fred must have thought of me last week.'

"From then on, her improvement was fairly steady. She asked if I would help her prepare a recipe book to use when she got home as her husband 'hadn't had a decent meal, he says, since I've been in hospital.' She told me that she was glad I had become her friend as now she wasn't bothered by those voices any more—the first time I had realized that she was hallucinating."

The faculty of the hospital believes that this move toward individual treatment gives the patient reassurance and support, gives the hospital a more "at home" atmosphere, enabling the patient to adapt himself better and to more easily ventilate his symptoms and fears. The student nurse gains a better understanding of neurotic and psychotic symptoms, learns to see the patient as a person instead of a group of symptoms, and learns the value of kindness (support) in therapy. The doctors benefit through the close contact and detailed, individual reports of the student nurses, which are genuinely helpful in revealing symptoms and evaluating progress.



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\*T.M. Reg. U.S. Pat. Off. for S.K.F.'s brand of chlorpromazine.

# The Institutional Care of Mentally Ill Children

## Administration and Therapy Problems at Rockland State Hospital

By ARTHUR W. PENSE, M.D.,  
Deputy Commissioner of Mental Hygiene,  
State of New York

and ALFRED M. STANLEY, M.D.,  
Director of Rockland State Hospital,  
Orangeburg, N. Y.

ROCKLAND State Hospital has had a Children's Group of 150 beds, consisting of six cottages of 25 beds each, in operation since 1936. The age limit in this unit is 5 to 12 years. In addition we have in a separate building five wards of 25 beds each on the male adolescent service and three wards of 25 beds each on the female adolescent service.

Our admissions consist of children and adolescents showing neurotic manifestations, primary behavior problems (which include the psychopath) and those with delinquency tendencies, character disorders, and finally childhood or adolescent schizophrenia.

The problems of the two age groups differ in many respects both administratively and therapeutically. The problems vary also, according to the type of clinical symptoms shown. The seriously ill schizophrenics, whether in the early age group or in the adolescent period, require a different type of program than the behavior problems, neurotics and character disorders. The latter groups need closer supervision from a security standpoint as they tend to gang up and create problems which we do not find among the really sick children. The severe schizophrenics need individual attention and care to a much greater extent. The adolescent problems are much more immediate and explosive and because of their aggressive, more hostile behavior and the maturing of their sexual drives, we find a much higher incidence of delinquent traits among the older children than we do among the younger children.

We have set up a ratio of ward personnel in all these children's services of one to three on a 24-hour program as a minimum level at which we can

properly function. A one to two ratio would be desirable. Ward personnel for these services must be carefully selected with emphasis on flexibility, interest in children, and above all, a mature and stable personality.

### Personnel Attitudes Vital

The whole therapeutic program must be organized as a complete unit on a 24-hour basis. We do not feel that a completely permissive atmosphere or program is the most successful one. The children must learn to relate with each other and with adults and learn certain respect for authority. The attitudes of all per-

sonnel involved are highly important in this learning process. In the total program of therapy, we are using individual psychotherapy, group psychotherapy, group activities, somatic therapies, occupational therapy, play therapy, recreation and education. Our experiences with the newer drugs such as Reserpine and Chlorpromazine, while encouraging, are not far enough advanced for us to draw any definite conclusions.

With the younger children, we find that therapy built around educational lines is highly important. Children in both groups have serious speech and reading disabilities. By working



### Outdoor Recreation Facilities Desirable

*The batting side watches tensely from the side lines as a teammate tries to beat the ball to first base. Baseball furnishes excellent opportunities for these emotionally disturbed children to learn how to cooperate with others.*



#### **Children Enjoy Seeing the Products of their Work**

*With the help of Mrs. Mae Syko, an occupational therapy instructor, a young patient learns the rudiments of sewing by making clothes for her doll. She also made the doll herself. A sense of accomplishment helps a disturbed child towards a proper appreciation of her own value as a person.*

with these problems and building our other therapy around this approach we feel we accomplish more. In education we are trying to place the emphasis on vocational training. At present, because of overcrowding, our facilities for vocational training are limited but the children are given the opportunity to learn how to live with others and receive instruction in various types of work which they might use at a later date. In the younger group we are able to have the children attend classes in mixed groups. In the adolescent services, we have not been able to do this because of our set-up. We do, however, have mixed groups in recreational activities. This creates problems but we feel it is highly important that the boys and girls learn to relate to one another, and to understand the problems and learn how to handle their drives while in the institutional setting, just as they would have to do in the community. An attempt is made to motivate the leaders of these groups in proper conduct and to have them identify

themselves with socially acceptable goals.

#### **Half-Way Houses Projected**

One of our most difficult problems arises when children are ready to leave the institution. While they are hospitalized every effort is made with their families and adults in the environment from which they came to bring about a suitable environment for their return. At present we have a projected program of opening half-way houses where boys and girls may be placed out of the hospital under a semi-protective influence, in small groups of about 12 and it is our hope that when these are established they will be helpful in bringing about the transition from the hospital to community life.

#### **General Planning for New Units**

In planning for the new facilities required by the New York State Department of Mental Hygiene for mentally ill children, consideration was given to the planning going on in

other States, the 20-odd years of experience gained from the operation of children's units at Rockland and Kings Park state hospitals, and the more recent experience with older children who have been coming to Rockland State Hospital in relatively large numbers.

On the basis of this experience certain general principles were established to guide the planning in order that the best possible therapeutic atmosphere might be provided.

#### **Best Located Near State Hospital**

One of the most serious problems was the location. It was finally decided that these units should be located preferably on the grounds of a state hospital, but certainly near an institution with a mental hygiene orientation so that the basic service facilities of an institution would be available. Aside from the economies involved, experience has indicated that staffing is one of the major problems of children's psychiatric services. The associated state hospital provides a reservoir of personnel who can be called upon to provide the immediate staff replacements found necessary, as many persons assigned to work with mentally ill children find that they cannot adjust to the situation for an extended period of time. There are also obvious advantages in this location for the training of the state hospital residents.



*Mrs. Syko lends a helping hand to a member of the art class she conducts in the O.T. Center. Boys and girls work together. In the background an aide adjusts the loom for a boy who prefers to weave.*

It is considered advisable that the unit be situated as far as possible from the adult patient area and be given a name which distinguishes it from the parent hospital. If possible the staff for the children's unit should be separate and distinct, except that the director of the state hospital would have the overall responsibility. The psychiatrist in charge of the children's unit should have the responsibility for the treatment program and participate actively in the selection of its personnel. The psychological, social service and other professional staff should be independent of the main hospital except for the general professional supervision from the supervisors of the particular professional areas.

#### Adequate Size for Proper Classification

The determination of the size of the unit presented the greatest problem. Our earlier experience had been with units for not more than 125. As the admissions increased and were no longer selective, the wider range of cases both as to behavior and duration of residence revealed the limitations of a smaller unit. An analysis of the children indicated the desirability of a classification into not less than eight groups for each sex. It was believed that this would adequately cover the range of age groups from five (and less) to sixteen (plus some immature 17 and 18 years olds), permit separation of the aggressive from the non-aggressive, and meet the other practical classification problems. As the cottages are being planned for 25, facilities for 400 children appeared to be the most practical size for good classification; that is, eight 25 bed cottages for each sex. A discussion of the advantages and disadvantages of completely separate units for boys and girls led to the conclusion that both sexes should be in the same unit.

It is probable that there will be more boys than girls. This problem will be met by the most flexible possible arrangements that can be worked into the planning of the unit by the architect. The larger sized unit was also considered to have advantages from the standpoint of the provision of a broader educational and vocational program. The range of educational requirements is great; these children have an educational range

extending from kindergarten into high school. The flexibility possible with a larger educational organization is obvious.

#### Each Cottage Has Playground

A cottage system was considered necessary and a capacity of 25 was established as maximum size. It was decided that the dining room should be in the cottage but that the food could be brought to the cottage from

a central kitchen in the unit, preferably through corridors. For purposes of economy two cottages will share a common food-serving room. The corridors can also be used to reach the separate school and vocational training building during inclement weather.

It was considered desirable that each cottage have its own playground to maintain the cottage atmosphere and develop the security that goes with belonging to a group.



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## The Lessons *FIRE* Taught Us

A. M. GEE, M.D., Director\*  
Provincial Mental Health Services  
Essondale, British Columbia

**T**HE accompanying group of photographs presents dramatically the progress of the fire that totally destroyed the Industrial Therapy Shops of the Provincial Mental Hospital, Essondale, B. C., on May 5, 1955.

The alarm was turned in at 5:10 P. M., about an hour after the working patients had left the shops to return to the hospital proper.

The fire started in the upholstery shop, probably from a cigarette butt dropped into a trash can (without a lid). Although the usual check of the building was made by the employees before leaving, no fire was detected, but this is not surprising as the felt scrap, etc., in the trash can could smoulder for some time and the fire not be apparent.

The structure of the building contributed to its rapid destruction. It was wholly of frame construction; there were V-joint walls and ceilings in the shops and corridor. The exterior was of red cedar shingle. There were no fire breaks in the building and the attic area of the main corridor was not interrupted in any way. Contributing to the fire's progress was the air coming through the louvers in the roof gables. On the day of the fire a strong wind was blowing (over 25 miles per hour).

It soon became apparent to our fire department that they would not be able to save the building but they continued to do what they could to control the fire with the fire hoses.

The vigor of the fire combined with the force of the wind presented a problem of flaming debris falling all about the institution. Many volunteers joined with staff firefighters to combat the spot fires that resulted from the flaming debris. The roof of our bakery was ignited, and fires occurred in the Public Works Building, the garages and on the roof of the Center Lawn Building. This latter fire was a particular hazard because the building houses 600 patients (including 2 wards of sick and infirm) and because the firefighters could not get direct access to the roof to combat the fire. It was necessary for a man to go up four stories to the attic, where he was able to get out on the steep tile roof on a rope, dragging a small hose with him. We were fortunate in being able to reach these fires quickly as they would soon have reached the stage where they would have been sending debris into the attic air-intake of the ventilating system.

We learned that open windows in attic quarters (occupied by staff) are a potential hazard for the reception

of blazing debris from a nearby major fire.

We also learned that a problem was created by the special locks (not opened by the basic master key) that are placed on departments and supplies located in attic accommodation. While these special locks provide security for equipment and supplies they greatly impede the work of firefighters in getting to an outbreak in the area.

We discovered much about our fire department on this occasion and we were satisfied with the quality of their performance. The equipment on hand was good but there was one major lack — an aerial ladder truck. With this type of equipment it would be possible to reach roof and gutter fires on the high buildings from the outside and it would be possible to use a larger hose. The usefulness of such equipment in evacuating patients trapped in the upper stories is apparent.

Plans are now being developed to build a new Industrial Therapy Center. Needless to say, the new structure will be constructed of fire resistant materials, and equipped with a sprinkler system, fire doors and other devices to impede the progress of a fire.

\* See Page 10-Editorial.

## Progress of the Essondale Fire

Photos by Audio-Visual Dept  
B. C. Mental Health Services



**Above:** Flames spurt out of the wing housing the upholstery department, where the fire started (shown also on opposite page).



**Left:** Spreading to the main corridor of the building, the fire begins to creep along the roof. Its long lines were unbroken by fire breaks which would hinder the spread of flames. Note the smoke pouring through the attic louvres, which drew in air to feed the fire inside the building.

**Right:** Firefighters attempt to retard the progress of the roof fire, which spread rapidly, aided by prevailing winds and the building's own lack of fire protection.

**Below left:** The next morning: what was once the Industrial Therapy Shop is now a scene of total destruction. Close by can be seen the main buildings, which house patients.

**Below right:** A close-up of the debris shows the twisted ruins of valuable shop equipment.



## EDITORIAL

The recent fire which destroyed the Industrial Therapy Shops at the Provincial Mental Hospital, Essondale, British Columbia, (See Pages 8-9) is an example of how devastating a fire in this department can be.

Industrial shops must of necessity store a supply of the material used in their daily work. Many of these materials are combustible, and need only be ignited to create an emergency.

The one fortunate thing about the British Columbia fire is that the building containing the shops was completely detached from buildings occupied by patients or employees. For this reason, and because the fire started after patients had left their assignments for the day, the danger to human life was relatively small, despite the undoubted hazard of flaming debris described by Dr. Gee. But had this fire occurred in any one of the many hospitals where the industrial shops are located in basements or other parts of buildings occupied by patients, the results could and probably would have been disastrous.

The following principles are suggested for use in connection with future building plans:

1. Industrial therapy shops should be located in separate buildings, of fire-resistant construction.

2. Fire stops, automatic sprinklers, and a fire alarm system should be included in the plans for such buildings.

3. Carefully formulated fire rules and regulations should be established, and a system of regular inspection by persons trained in fire protection should be inaugurated.

Generally speaking, attics and basements in buildings occupied by patients or employees should not be used for shops or for storage space because of the fire potential which is always created. When such a situation cannot be avoided, the space used should be equipped with modern devices for the prevention, detection and extinguishing of fires.

Ralph M. Chambers, M.D.  
Formerly Chief Inspector, C.I.B.

## Public Health Service Increases Traineeship Grants

The U.S. Department of Health, Education and Welfare announces that the support provided by the Public Health Service traineeships awarded each year by the National Institute of Mental Health has been increased. The new annual rates of support authorized by the National Advisory Mental Health Council are as follows:

Level 1	\$1,800	Level 4	\$2,800
Level 2	\$2,000	Level 5	\$3,400
Level 3	\$2,400	Level 6	\$4,000

The year of graduate or advanced training in the speciality for which an applicant is eligible determines the level of the traineeship which will be granted. Advanced training is defined as: 1. Psychiatry: psychiatric residency training; 2. Clinical Psychology and Psychiatric Social Work: training beyond the bachelor's degree; 3. Psychiatric Nursing: training beyond the R.N.; 4. Public Health: training in public health after psychiatric specialization.

The public health traineeships may be awarded to psychiatrists, clinical

psychologists and psychiatric social workers. Traineeships may also be awarded for mental health training for public health nurses. Traineeships in Psychiatric Nursing are awarded at Level 2 for study at the baccalaureate level, and at Levels 3, 4 and 5 for graduate study.

Traineeships are designed to cover a full annual unit of training. "Annual unit of training" is defined as (1) a period of training up to twelve months or (2) an academic year (i.e. three quarters or two semesters), whichever applies to the specific training plan. No trainee shall receive more than one traineeship unit within a twelve-month period.

A list of schools authorized to administer Public Health Service traineeships in psychiatric nursing is available on request from the Training and Standards Branch, National Institute of Mental Health, Bethesda 14, Md.

Information can also be obtained on the annual rates for all traineeships.

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Orientation for Psychiatric Technician Trainees (Patton St. Hosp.) 1 lb.

Instruction Guide for Psychiatric Aides In-Service Teaching (St. of Minn., Dept. of Public Welfare) 1 lb.

In-Service Program for Attendants (Alexian Brothers' Hospital) 2 lbs.

Outline of the Basic Course of Instruction in Neuropsychiatric Nursing for Hospital Aides (V. A. H., Albany, New York) 2 lbs.

Attendant Training Manual (Enid State School) 2 lbs.

Official In-Service Advanced Train-

ing Program for Aides (Kansas Dept. of Social Welfare) 1 lb.

Course Outline for the Basic In-Service Aide Program (Topeka State Hospital) 1 lb.

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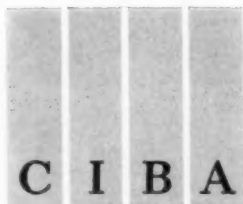
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# ARCHITECTURAL STUDY

## The Nebraska Psychiatric Institute

Dedicated to the training of professional mental health personnel, the Nebraska Psychiatric Institute is an integral part of the University of Nebraska Medical Center. Its construction was financed equally by the University, the Nebraska Board of Control, and the Hospital Advisory Council of the State Board of Health.

Foreword by the Architect—JOHN LATENSER, JR.

**P**LANNING the Nebraska Psychiatric Institute was an adventure in architecture. In November of 1951 the writer, full of the knowledge of conventional mental hospital plans, went to the Nebraska Psychiatric Unit, then in temporary quarters, to call on the Director and discuss the requirements of the proposed new building. Before long it became apparent that some guiding spirit and some idealistic philosophy of healing was entrenched here, which would demand a hospital building different from anything I knew.

### Special Requirements

Because one must creep before one walks, the first set of sketches followed pretty much conventional lines and portrayed a five-story building. At our first sketch conference, the Director very courteously pointed out that the sketches did not permit certain procedures he planned, that certain other arrangements were not suitable. This, of course, meant more sketches—a whole succession of them. It gradually became evident that certain specifications must be met in addition to the usual architectural and budgetary ones:

Any evidence of institutional appear-

ance and any evidence of restraint was anathema.

These sick people could best be treated in a pleasant, normal atmosphere.

Surroundings must be attractive—such as one would find in a good hotel.

Whenever possible, patients should be able to go out into the yard, which should be attractive and interesting. All patients not too seriously ill would eat in a common dining room for both sexes; the dining room must be as attractive as that in a good club. There must be many and varied provisions for the important teaching and training activities of the Institute. Extensive areas were required for occupational therapy, a library, a social lounge, a music room, a gymnasium for exercising, a beauty shop, a barber shop, and a snack bar with adjacent kitchen where interested patients could improve their cooking. In fact, the director demanded everything that would keep the patients active and interested.

### Outdoor Patio Developed

And so, over a period of seven or eight months, the sketches progressed, finally getting down to the little things, every detail taking on an

importance in its relation to the overall scheme.

The building which finally emerged is roughly in the shape of an elongated "H". It has two stories and basement with the basement on grade at the ends and in the rear. In addition there are two separate but attached activity buildings, one for adults and one for children. The area between the two rear wings was made an outdoor patio with the adult activities building and a fireplace wall completing the enclosure.

### Structural Details

Structurally the building is wall bearing with reinforced concrete columns, girders, and slabs, except that the adult activities building has an ordinary construction roof. Floors generally are asphalt tile. Ceilings are largely acoustic tile. Air conditioning is limited to the two acute wings, the nursing centers, and the insulin treatment recovery room. All other patient areas, inside rooms, and corridors are heated and ventilated by forced air. Outside rooms in non-patient areas have steam radiators.

Let me repeat—planning the Nebraska Psychiatric Institute was an adventure in architecture.



## Teaching and Treatment Facilities in New Institute

By CECIL WITTON, M. D., Director

**T**HE decision of such a relatively small state as Nebraska to invest \$1,500,000 in a psychiatric training hospital placed upon those responsible for its planning a special obligation to produce an economical comprehensive building. Fortunately, we did not have to compromise our planning since it was agreed at the outset that the facility should be primarily for teaching and not intended as a receiving or custodial hospital. In addition, because the Institute is an intimate part of the University of Nebraska medical center, it was not necessary to duplicate certain facilities such as service units, clinical and research laboratories, and some diagnostic and treatment elements.

The Nebraska Psychiatric Institute is a hospital dedicated to the instruction and training of all professional persons having to do with mental health. Therefore, it was necessary to incorporate adequate facilities and opportunity for each

of these disciplines to carry out its function. It was early decided that we would not be wedded to any philosophy or technique then current. The building had to be flexible in design. In projecting the teaching and training activities we estimated that about 1,000 individuals would receive some instruction or training in the Institute each year. This meant, among other things, that special precautions had to be taken to protect the patients' rights. Special attention had to be given to problems of traffic; provisions had to be made for indirect as well as direct observation. Ample examining, demonstration, lecture and seminar rooms had to be included so that the teaching program would not interfere with patient care.

Prior to deciding the inpatient capacity of the hospital, we sought opinions of a large number of persons in academic psychiatry. Their consideration was also solicited as to size from the standpoint of economy of

operation and our particular needs.

All of the aforementioned considerations played a major role in the planning and design of the Institute. The resulting building, located on the campus of the University of Nebraska College of Medicine in Omaha, encompasses 93,000 square feet with approximately one half of this area being devoted to patient services. The remainder consists of teaching, laboratory, and administrative areas. Treatment facilities are provided for inpatients, outpatients and day patients. Separate and special provisions have been made for children, adults, and the aged. There are 96 beds—60 for adults, 10 for geriatric research, and 26 for children. Use has been made of various teaching aids such as 17 one-way mirrors with two-way sound equipment, a multiple camera television system, and other special observation devices. Anticipating the rapid development of television as a training tool, conduits were built into the building to

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accommodate wired industrial television equipment.

The most effective method for describing the Nebraska Psychiatric Institute is to discuss its service by service, since it was designed and operates in this manner.

### Adult Inpatient Service

Just inside and to the left of the front door of the Institute are a waiting room and admitting rooms for adult inpatients. They are directly across from the information and admissions desk and convenient to elevators and stairways leading to the second floor where the main part of the adult inpatient service is located. In contrast to the traditional multiple story approach, the six wards of this service are all located on one floor, thus increasing flexibility, ease of teaching, and economy of operation. Provisions have been made for the simultaneous care of every type of mental disorder with special areas designed for the full range of treatment techniques.

Male and female patients are in separate wings of the building. A nursing center at each end of the central treatment wing serves as the hub from which the acute, intermediate, and open wards radiate. Thus the transfer of patients from one ward to another is made a simple, innocuous matter, eliminating changing of psychiatrists and nurses, and transfer of records. The treatment wing has, in addition to specially designed areas for the physical therapies, offices for the clinical director of the adult inpatient serv-

ice, his assistants and residents, individual rooms for psychotherapy, and a seminar room for staff meetings and teaching small groups.

Since it is our belief that social therapy is one of the most important aspects of psychiatric treatment, much thought was given to the designing of areas where male and female patients could mingle together. Although living rooms are provided on each ward, most recreational and social therapy takes place in the outdoor patio or in the adult activities building which is connected to the main structure by a glassed-in corridor and sun porch. All patients, except those who are acutely ill, eat together in the lower floor dining room, reached by a stairway restricted to patients and ward personnel.

The activities building contains a social room, patients' kitchen, library, music room, barber shop, beauty shop, patients' laundry, gymnasium, and offices for the psychiatric social group workers who direct the recreational therapy program. In addition, this building houses an occupational therapy area large enough to accommodate inpatients and daypatients without crowding, and designed to facilitate teaching and training of occupational therapists and other students. Waist-high counters separate the weaving, ceramics, leather, and other craft areas. The wood-working area is enclosed by glass partitions to confine noise and dust. The occupational therapists' office is also enclosed in glass and is so situated that the entire area can be observed from its confines.

### Daypatient Service

Special attention was given to daypatients in the planning of the building. Lounge and restrooms with showers and lockers are provided for them on the inpatient open ward. In addition, other facilities such as the patients' dining room, recreation area, occupational therapy, etc. were located and sized to accommodate both inpatients and daypatients.

### Geriatric Service

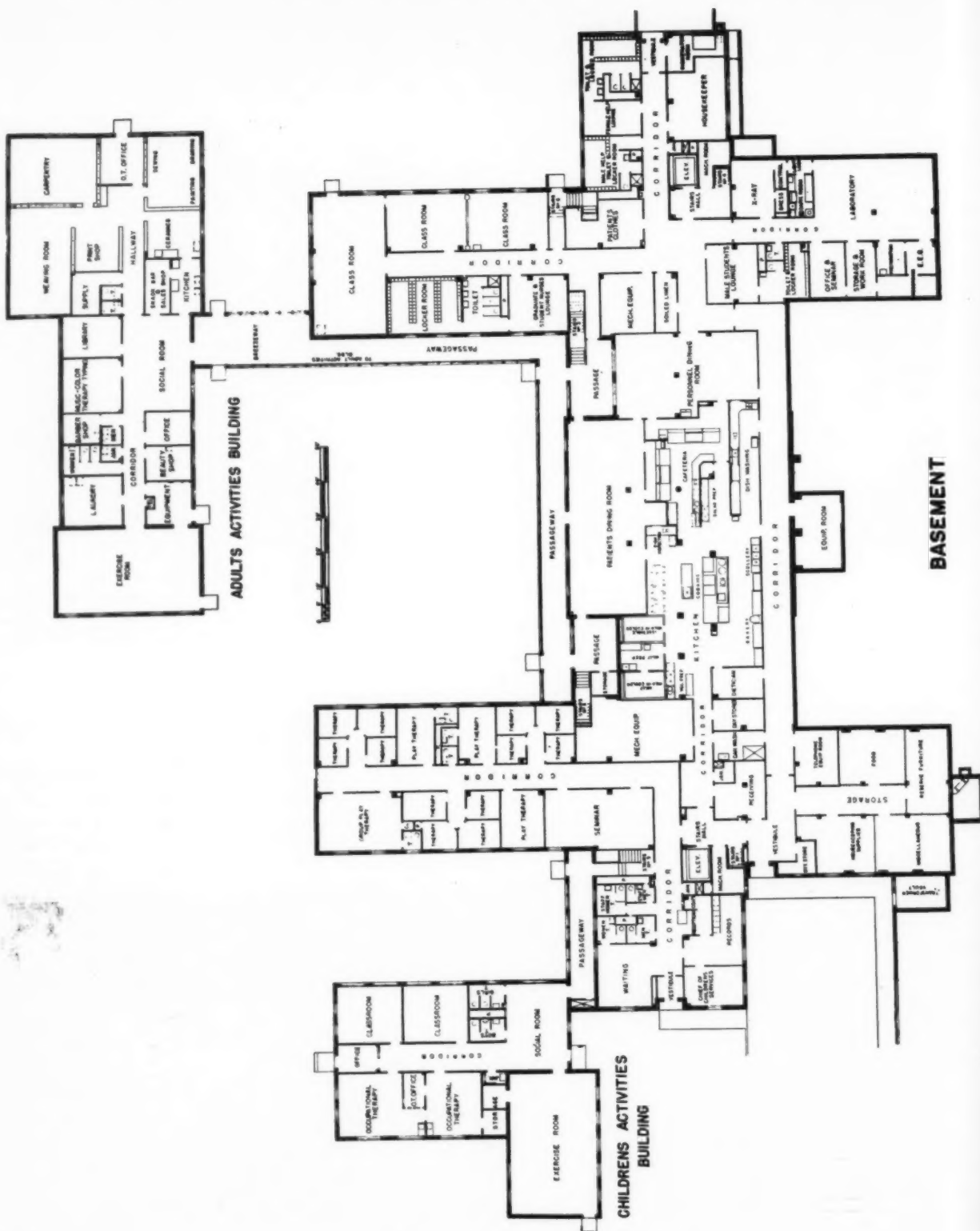
A ten-bed geriatric research ward is located on the first floor of the Institute building. This is designed to operate as a separate and self-contained unit having its own living space, bedrooms, infirmary, nutrition laboratory, treatment room, research laboratory, access to elevator, and an additional and separate stairway. In this ward, as in all of the other service areas in the building, an infirmary has been provided. In this instance, two adjoining two-bed rooms open into a secondary corridor containing a nurse's desk, locked cabinets, and toilet. Glass windows form the dividing wall. This arrangement permits one nurse to special four acutely ill patients. It is equally adaptable to restless or noisy patients.

### Adult Outpatient Service

The adult outpatient service is on the first floor immediately adjacent to the main entrance and across from the admitting and information desk. There is an outpatient waiting room adjoining the secretary's office, a combination office and conference room

(Continued on Page 17)





(Continued from Page 15)

with one-way mirror for the clinical director of the service, and 16 other offices arranged in groups of four for faculty and students. Two-way mirrors between faculty and student rooms readily permit supervision. Across from the outpatient waiting room are headquarters for the social service division and the clinical psychology division.

#### Children's Service

The children's section with provisions for both inpatients and outpatients is treated as a separate entity, although both its floors are under the main roof. On the lower floor is the children's outpatient service with a separate outside entrance. Offices for the clinical director and three psychiatric teams (in our situation a team is a psychiatrist, psychologist, social worker, and trainee) are also located on this floor. There are four play therapy rooms, each adjacent to an observation room with a one-way mirror.

Immediately above this section is the children's inpatient area consisting of a ward for boys, one for girls, a four-bed infirmary, nursing center, living room, and dining room. The children's activity building is connected to the rest of the service by a corridor on the lower floor level. This building contains a social room, occupational therapy area, gymnasium, and classrooms. Offices are provided for occupational therapists, teachers, and social group workers. Immediately adjacent are outdoor play yards for large and small children.

#### Offices & Classrooms Separate

The main lecture hall of the Institute is on the first floor and has its own outside entrance so that medical student classes and public groups need not go through other parts of the building. At other points in the building are three large classrooms and eight seminar rooms for smaller groups. Offices have been provided on the first floor for the administrative and clerical staff and additional teaching personnel. The lower or basement floor contains, in addition to the patient areas already mentioned, the personnel dining room and lounges, a special section for EEG and X-ray, the kitchen and other service areas.

The furniture used in the building is of the dormitory or hotel type except in the treatment areas. All furniture and interior decorating is light and bright. Hospital or institutional type furnishings and colors have been avoided.

On May 9, 1955, the contractors finished all except their pick-up work. On May 10 patients were moved into the building. It is a tribute to the architectural firm of John Latenser and Sons that this complex facility

was able to function immediately as planned. There has been no need for alterations except of a very minor nature.

Special mention should be made of the cooperative assistance given by the technical and professional staffs of the University and the Board of Control, without whose integrated efforts the Nebraska Psychiatric Institute could not have been constructed for so much less than national experts estimated.

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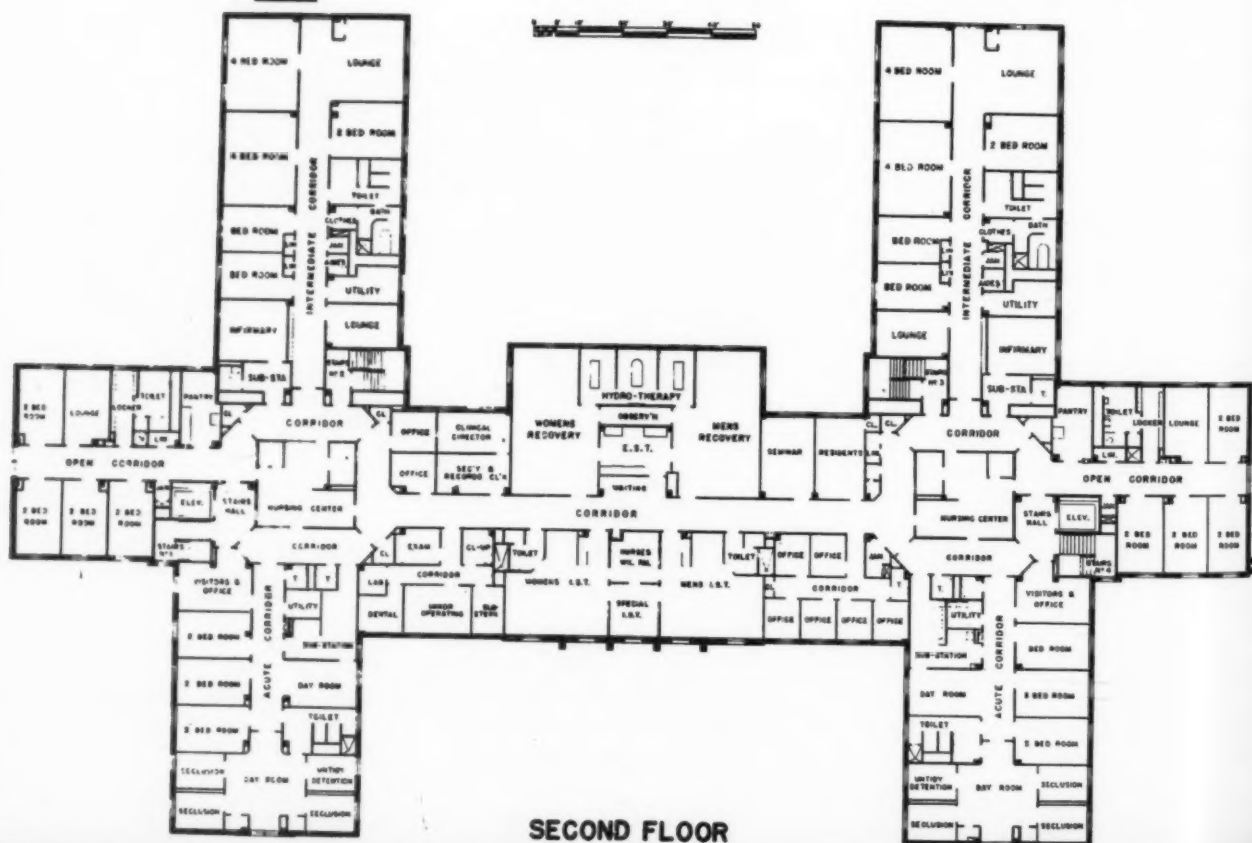
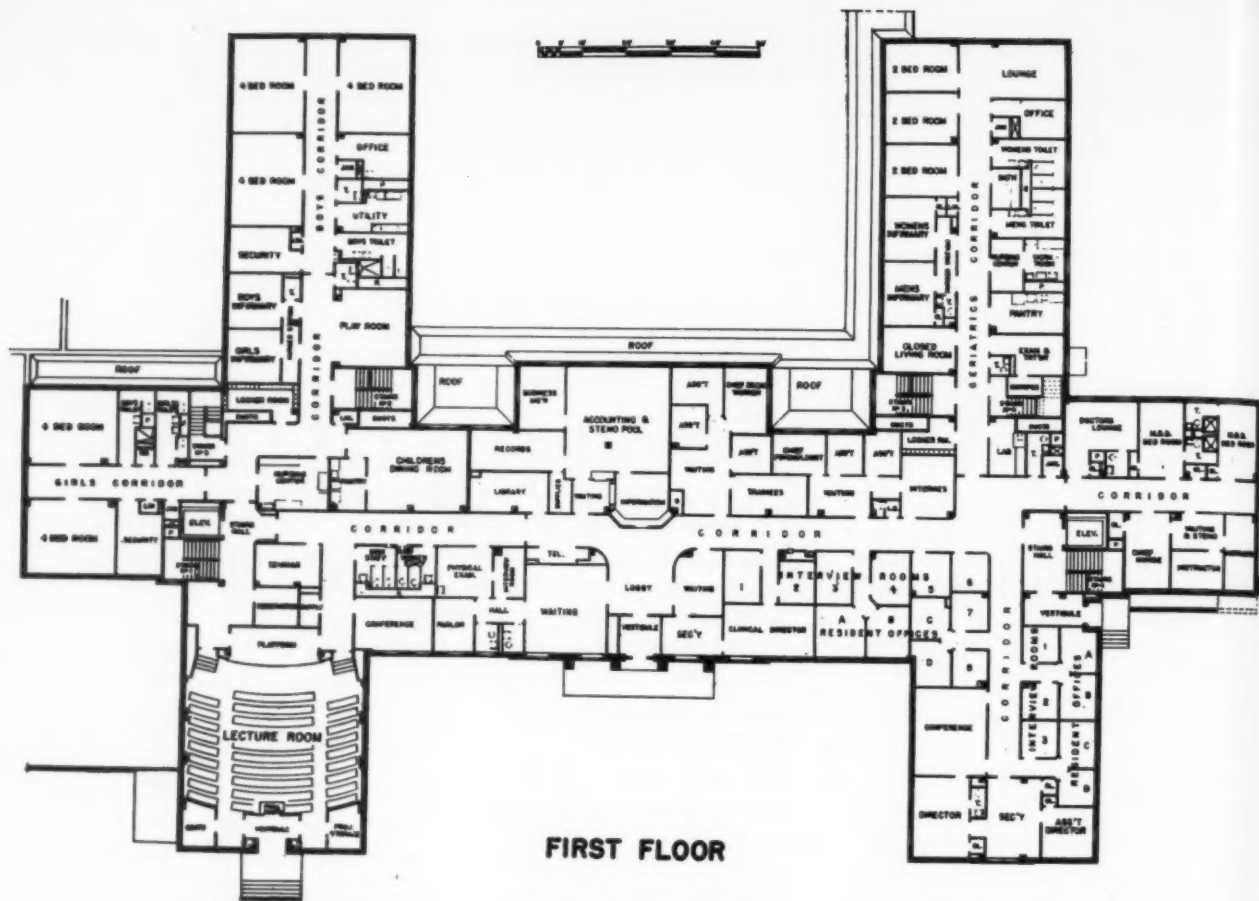


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## BOOK REVIEW

### BETTER SERVICES FOR MENTALLY ILL PATIENTS: Proceedings of Institute on Social Work in Psychiatric Hospitals (Ruth I. Knee, Editor)

This is a report of the proceedings of an Institute on Social Work in Psychiatric Hospitals held in June 1954 by the American Association of Psychiatric Social Workers, assisted by a grant from the National Institutes of Health.

The stimulation for the Institute was provided by the findings of an earlier study made by the American Association of Psychiatric Social Workers, on "The Practice of Social Workers in Psychiatric Hospitals and Clinics" by Tessie D. Berkman. This study revealed many lacks in service, raised many questions about the differences between social work practice in psychiatric clinics and in psychiatric hospitals, and indicated the sizable number of untrained or only partly trained social workers found in hospital programs. Professionally educated social workers have been more interested in the challenges of clinic work than in struggling with the serious basic lacks in mental hospital programs. This study also showed a recent shift in the other direction. New knowledge of, and interest in, the treatment of the mentally ill, and the increased concern of states and the general public about the enormity of the problem, are two factors in this trend. These developments indicated the need for reviewing current social work programs in psychiatric hospitals, and to consider how to strengthen them in all areas.

Social workers from voluntary hospitals, from training and research hospitals, and from federally supported hospitals attended with representatives from 38 states, Puerto Rico and Canada. Consultants came from the fields of psychiatry, psychology, psychiatric nursing, research, night and day care, group work, vocational rehabilitation, family service, public welfare, the private hospital, and the psychiatric service of the general hospital.

The Proceedings are divided into two parts: Part One consists of papers presented in the General Sessions, and Part Two summarizes the Workshop discussions. The papers present cur-

rent philosophy and concepts in the fields of social work and psychiatry. The Workshop findings and reports are summarized under five headings: "Essential Social Services", "Administrative Factors in the Provision of Essential Social Services", "Staff Development and Training", "Community Relationships", "Recommendations".

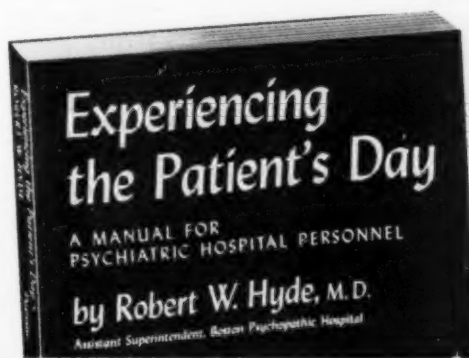
This report is important and useful, to both social work and psychiatry as a description of social work practice in psychiatric hospitals. It reflects generally the experience of social work in this special setting. On the basis of the amount of space and thought devoted to it, there was far more interest in the "Essential Social Services" than in any of the other functions of psychiatric social work. This is not only the area in which social work sees the primary emphasis, but it is also the most familiar area, the traditional service. In this section, social services related to all aspects of the patient's hospital experience are discussed. No attempt is made to suggest priorities, and prob-

ably rightly so, since local needs and problems influence the individual programs of all hospital services.

It is hard not to wish, however, for some more qualitative or evaluative discussion of the multitude of services which social workers can and do provide. With the existing shortages of staff of all types, neither social work nor any other profession can perform all the services which it might conceivably render, and choices, based on optimum effectiveness, must be made. Some thought about this problem might have been helpful to the many hospitals and social service staffs who must work with it. It would seem necessary, in fact, to give some serious consideration to it before definite recommendations about staffing patterns can be made.

The report is well written, and is a gold mine of information and discussion material.

MARY M. STEERS,  
Chief Social Worker,  
Veterans' Benefit Office,  
VA, Washington, D. C.



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## PROGRAM TOPICS AND LEADERS FOR SEVENTH MENTAL HOSPITAL INSTITUTE

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STAFFING NEEDS FOR PATIENT FREEDOM  
Dr. George E. Reed, Montreal, Quebec.

ENVIRONMENT FOR GREATER PATIENT FREEDOM  
Dr. Paul Haun, Philadelphia, Pa.

ADMINISTRATIVE ASPECTS OF PATIENT FREEDOM  
Dr. I. L. W. Clancey, Weyburn, Sask.

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Dr. Henry A. Davidson, Cedar Grove, N. J.

ADMINISTRATIVE INTER-STATE RECIPROCITY  
Dr. Dale C. Cameron, St. Paul, Minn.

OUT-PATIENT CLINIC SERVICES FOR THE MENTALLY  
DEFICIENT  
Dr. Robert S. Garber, Skillman, N. J.

BARRIERS BETWEEN NURSE AND PATIENT  
Miss Mary M. Redmond, R.N., Washington, D. C.

CHILD PSYCHIATRY: COMMUNITY ASPECTS  
Dr. Exie E. Welsch, New York, N. Y.

CHILD PSYCHIATRY: HOSPITAL ASPECTS  
Dr. Fritz Redl, Bethesda, Md.

REPORT ON THE JOINT COMMISSION ON MENTAL HEALTH  
AND ILLNESS  
Dr. Daniel Blain, Medical Director, A.P.A.

ACADEMIC LECTURE: GROUP PSYCHOTHERAPY  
Dr. Jerome D. Frank, Baltimore, Md.

ADMINISTRATIVE CAREERS IN HOSPITALS  
Dr. Francis J. O'Neill, Central Islip, N. Y.

THE NEW DRUGS (CHLORPROMAZINE & RESERPINE):  
ADMINISTRATIVE ASPECTS  
(Discussion leader to be announced)

THE ROLE OF THE HOSPITAL IN PSYCHIATRIC PUBLIC  
RELATIONS  
Dr. Wilfred Bloomberg, Boston, Mass.; Mr. Edward Brecher, Leonia, N. J.

*The closing date for pre-Institute enrollments is September 26th and already over 160 applications have been processed. The Sheraton-Park Hotel Washington, D. C. will confirm all hotel reservations as they are received.*

*The Local Arrangements Committee Chairman is Dr. Addison M. Duval. Dr. Harvey J. Tompkins is the Chairman of the Program Committee, which consists of Drs. Granville L. Jones, Gale H. Walker, Mr. R. Bruce Dunlap and Dr. Lucy Ozarin.*

## Changing Concepts

The ferment in which psychiatry finds itself today provokes mixed emotions. On the one hand there is increasing interest in and tangible support of efforts to combat mental illness. There is also the sobering realization, substantiated by public opinion polls, of continued widespread ignorance, prejudices and misconceptions which impede the optimal development and proper utilization of our mental health resources. Added to this is the mass of material coming from legitimate sources, sometimes contradictory and often in opposition to long-held concepts.

This last is particularly true of the care and treatment of the hospitalized psychiatric patient. Happily, while there is an understandable desire to hold fast to what has been considered good, we have not bound ourselves to the past and continue to seek out what may be better.

Unhappily, however, the general public has endowed the word "research" with magical properties. Research money is increasingly available but in too many instances with unrealistic expectations of spectacular results. How often are we called upon to place in proper perspective the possibility of "wonder drugs" in psychiatry! How difficult it is at times to successfully impart legitimate reservations concerning the use of various therapeutic agents without creating the impression of dragging at the wheels of progress. It is agreed that psychiatry must share the blame for creating undue optimism, but we can help counteract this unhealthy tendency by an openminded consideration of advances made, and, through conscientious and thoughtful programming, stimulate and expand investigative efforts in a sound and orderly manner.

"Earmarked" research funds are a necessity. However, during this present wave of enthusiasm, potential sources of income may tend to limit their contributions to this purpose. To do so is to provide an unbalanced program by failure to recognize the immediate results in terms of patient improvement and recovery which would follow greater opportunities to apply to more patients what is now known.

The Mental Hospital Institutes have been and will continue to be an instrument to consider current progress, to strive for balance and help develop productive guide lines for the future. From the beginning there has been constructive impatience with the status quo and a controlled imaginative receptiveness of new thoughts and new ideas. This is the antithesis of unbridled enthusiasm, the ill effects of which cannot be explained away on the basis of expediency or the exigencies of the situation.

A review of the past deliberations of the various Institutes reveals repeated declarations that any consideration of any aspect of the hospital must be intimately related to the patient. This has pointed up the necessity for better understanding of patient requirements. This in turn has aroused concern regarding the need of better patient-oriented hospital construction, administration and therapeutic programs. It is the expectation of your Program Committee that the subjects and discussion leaders chosen for the Seventh Mental Hospital Institute will provide a stimulating basis for such discussions.

**Harvey J. Tompkins, M.D.**  
Chairman, Seventh Mental  
Hospital Institute  
Program Committee

#### Local Arrangements Committee Formed for Institute

Dr. Addison M. Duval, Assistant Superintendent of St. Elizabeths Hospital, Washington, D. C., who is Chairman of the Local Arrangements Committee for the Seventh Mental Hospital Institute, October 3rd-6th at the Sheraton Park Hotel, Washington, D. C., announces that the following local psychiatrists are members of the Committee: Drs. J. F. Casey, Director, Psychiatry and Neurology Service, Veterans Administration; Dr. Robert A. Cohen, National Institute of Mental Health and Dr. Jay L. Hoffman, First Assistant Physician, St. Elizabeths Hospital.

The Committee, which is in charge of the optional arrangements for Wednesday afternoon, October 5th, has planned visits to the National Institute of Mental Health, Chestnut Lodge, Rockville, Md. and St. Elizabeths Hospital. That evening the patients at St. Elizabeths are giving a repeat performance of the pageant, "Cry

of Humanity" based on the life of Dorothea Lynde Dix.

#### Ladies' Committee For Institute

An innovation, for this year only, is a local Ladies' Arrangements Committee, headed by Mrs. Winfred Overholser as Chairman. Other members include Mrs. Addison M. Duval, Mrs. Jay Hoffman, Mrs. Robert H. Felix and Mrs. F. J. Tartaglino.

The Committee, established because a larger number of delegates than usual are bringing their wives,

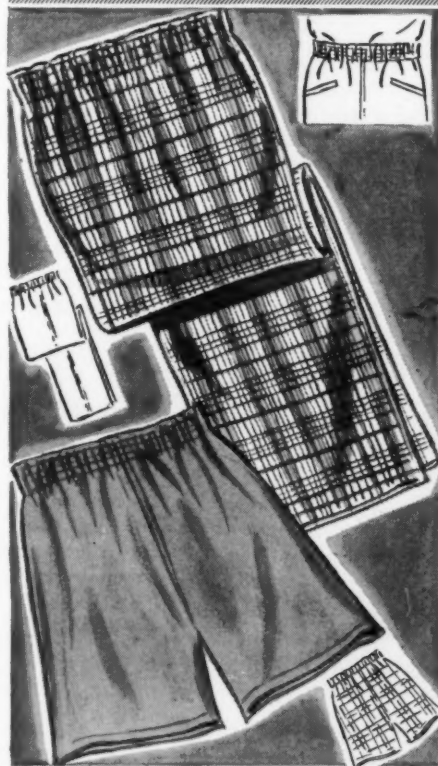
will make arrangements and have information available about sightseeing tours to points of interest in the capital, and other local information which may be helpful and interesting.

It would be helpful to Mrs. Overholser and her Committee if we could send her as early as possible the full number of ladies expected, so that she may proceed with her arrangements. All that is necessary is an indication on your enrollment form that your wife will accompany you.



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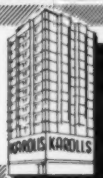
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# THE PATIENT DAY BY DAY

## Playpens Are Devised From Discarded Cribs

California's Sonoma State Hospital (for mental defectives) no longer sells for junk the metal cribs which are unusable, generally because of some mechanical failure. Instead, the cribs are converted into playpens which the hospital finds superior to the wooden ones it purchases. The conversion is achieved by cutting off the crib legs, spot-welding the corners, taking off the crib spring base, and repainting the frame.

The improvised playpens are about 20 inches longer than the commercial ones. They present virtually no maintenance problems, whereas repair costs on the wooden ones usually run about 50% of the original cost within the first six months of use. They also are much more durable, since the wooden pens seldom last longer than six months or a year, and can be used outdoors without fear of damage in case of rain.

The crib-conversion was the idea

of T. A. Bravos, the hospital's Assistant Superintendent, who says that the floorless playpens help the youngsters to walk. They are particularly useful for children with cerebral palsy and toddlers.

## Gray Ladies Work with Disturbed Children

The Gray Ladies of the North Suffolk County Chapter, (N.Y.) of the American Red Cross have set up a Scout program for emotionally disturbed children at Kings Park State Hospital. Six Gray Ladies are Den Mothers for three Cub Scout groups, and a Brownie Scout group is planned for the girls in the near future.

Twelve other Gray Ladies assist teachers in the regular class rooms, in occupational therapy and, remedial reading, and also help the children with letter writing.

During the summer months the Red Cross Canteen provides picnics for the children; Gray Lady hostesses provide refreshments and conduct games.

## Indigent Patients Given Weekly Allowance

Patients at Northville (Mich.) State Hospital with no family or friends to supply spending money are now receiving a small weekly allowance. Each gets fifty cents a week to spend, or save, as he sees fit. The money for this plan was made available by cutting off the small "salary" paid to patients who work in the canteen, on the basis that this was an occupational placement no different from other assignments. None of the canteen helpers objected when the reasons were explained.

This step made available \$320 a month for the allowance fund; a service club donated \$50, and employees are contributing. The fund is not large enough to serve all the hospital's 335 indigent patients, so the allowances are given to 186 younger ones. It was felt that they would benefit more from the morale-boosting allowance plan, since there is more chance of treating them successfully. The hospital hopes, of course, that enough money might be made available somehow so that the indigent geriatric patients can also get spending money.

## "Hard to Feed" Children Like Jellied Foods

In order to make the soft diet for difficult feeding cases more appealing, Mrs. Helen Galloway, chief dietitian at Polk (Pa.) State School, has the chopped foods mixed into Jello. Meat, fruits and vegetables, both cooked and raw, are served this way. The firmness of the Jello is varied according to the child's ability to swallow. Mrs. Galloway reports that the children seem to like the colorful variety this method of feeding offers. She cautions, however, that unless it is feasible to make individual Jello molds, the amount of chopped food varies in each portion. Thus, in order to make sure each child receives proper nutrition, more controlled feeding methods must be used as well.

## Tub Insert Eases Bathing of Geriatric Patients

Lacking special elevated tubs for bathing infirm geriatric patients, two of California's mental institutions have solved the problem with plastic



Missouri Patients Build Prize-Winning Float

This "Star of Hope" float was built by some 200 patients of State Hospital No. 3, Nevada, Missouri, as an Occupational Therapy project. Entered in the Vernon County Centennial Parade this past July 4, the float, whose theme represents the patients' hopeful belief in their cure, won second prize. This recognition not only provided a great deal of satisfaction for the patients who built the float, and for the entire hospital, but also made a good impression on the townspeople. The parade was routed through the hospital grounds, and most of the patients gathered on the lawn to view the procession.

tub inserts. The inserts fit into regular bathtubs, making it possible to bathe the patients at a convenient height. They are made of a lightweight yet very durable plastic, are stainproof and easy to clean. Both hospitals, the Sonoma State Hospital and the Rancho Los Amigos (a geriatric facility operated by Los Angeles County), report that the tub inserts save the nursing personnel much effort and time. The units are manufactured by the Wizard Corporation of Costa Mesa, California.

### Remembrance Fund Established to Provide Patient Comforts

At the January meeting of the Board of Managers on the suggestion of the Vice President, Mrs. William T. Campbell, it was proposed to the Board and unanimously approved, that the Board of Managers ask the Association of the New Jersey Neuro-Psychiatric Institute to undertake a program known as the Remembrance Fund.

The association is to encourage numerous friends, relatives, and acquaintances to contribute to the Remembrance Fund in the name of those who are ill or in memory of those who have passed away, instead of sending flowers.

These contributions will be placed in the Association's Building Fund specifically for a patients' store. Upon receipt of each donation, the Association will forward a beautifully engraved card to the person in whose name the contribution is made, notifying him of the donation to the Patients' Fund of the New Jersey Neuro-Psychiatric Institute by his friend.

Many people today appreciate that their money can better be spent in providing some of the niceties not provided by budgeted funds for patients in institutions; it is believed therefore the idea will flourish.

In addition we are contemplating publicizing a similar program well in advance of the next Christmas holiday to encourage people to utilize this idea instead of sending elaborate Christmas cards.

**ROBERT S. GARBER, M.D.**  
Superintendent  
N. J. Neuro-Psychiatric Institute  
Princeton, New Jersey

## Individual Orientation for Volunteers

By DOROTHY H. MARTIN

Director, Volunteer Services

Topeka State Hospital, Topeka, Kansas

**O**UR usual procedure for orienting new volunteers has been to give them ten hours of lectures before taking them on an assignment under the supervision of the director of Volunteer Services or other staff members. I have always felt that much of the lecture material was wasted because of the volunteer applicants' lack of knowledge of mental illness and of hospital routine.

I had this in mind when I interviewed two volunteer applicants who knew nothing of the hospital, little about mental illness and were quite nervous about attempting volunteer service. They came with a very real desire to be of service but with the feeling that their inexperience and lack of knowledge were perhaps too great a handicap. I recognized that they both had potential as volunteers if they could be made to feel secure, but that they could easily be frightened by situations with which they had not the knowledge to cope. I decided to try a new approach.

### Personal Orientation First

After talking with them I suggested that I should give them some personal orientation before the lectures and show them some of the hospital. I promised that they would not be given an assignment or asked to take any responsibility until they themselves felt ready to do so.

We went first to an open ward where we visited with the patients. We then visited several closed wards where the music therapists were conducting rhythm bands. The volunteers sat with the patients and participated. We visited volunteer groups who were engaged in playing games, having parties and going for walks. We went to gym classes with different types of patients and to several music listening groups. One of the doctors met with the volunteers while they asked questions and discussed what they had seen that they had not un-

derstood. We then took them on to a maximum security ward with the doctor, a therapist and myself in close attendance.

All of these assignments were done in two hour units with the last half hour of each a question period after we had left the patients. The volunteers spent sixteen hours on observation before they had six hours on trial assignments, one with a therapist and the other with an experienced volunteer.

After this they had the usual ten hours of lectures and then undertook a regular assignment as trained volunteers.

### Observation Period Valued

One of these volunteers now conducts a reading and discussion group and the other works with another volunteer on individual projects on a ward which requires a volunteer who can bring out some response from the patients. They have been at ease with the patients from the first and have assured me that they are having a wonderful time. They have both told me that they would not have been able to do this without the observation period and they certainly would not have gotten so much from the lectures without it.

In summing up, I believe that these two volunteers have proved that we might have more useful volunteers and certainly more secure ones if they could all have this support and attention when they first come into the program. I have had no other volunteers who adjusted so rapidly and so well without previous knowledge of volunteer service and mental hospitals.

I intend to use this method of orientation in the future as much as time permits. A volunteer who is happy and secure is certainly one who can do the most for the patients and who is our best salesman in the community.

# DEPARTMENTS

## Ohio Establishes Research and Training Bureau

The legislators in Ohio recently passed a bill establishing a new Bureau of Research and Training in the Division of Mental Hygiene of the Department of Mental Hygiene and Correction. This act designates three intensive treatment centers, at Cleveland, Columbus and Cincinnati, as state psychiatric institutes. The research and training activities of each of the centers are to be related to the three medical schools in the state—Western Reserve, University of Cincinnati and The Ohio State University.

A second bill raised salaries of Civil Service physicians, nurses and others.

A bond issue for \$150,000,000 to enable Ohio to establish an adequate construction program has been authorized by the legislature, but is still awaiting the results of an electorate vote.

## Third Administration Series Held at Menninger School

The Menninger School of Psychiatry's third annual series of seminar sessions on psychiatric hospital administration was held this year in January and March. The seminar was attended by 24 third-year psychiatric residents and staff psychiatrists of the Winter VA Hospital, Topeka State Hospital, and the C. F. Menninger Hospital. It was conducted by Dr. R. C. Anderson, Manager of Winter VAH, Dr. Alfred P. Bay, Superintendent of Topeka State Hospital, and Mr. Irving Sheffel and Mr. Thomas Dolgoff of the Administrative staff of the Menninger Foundation.

Three major areas of administration—organization, communication and authority—were emphasized in the twelve sessions, and their principles were applied to specific administrative problems the participants had encountered.

## Medical Record Librarians Meet at Downey VA Hospital

A seminar for medical record librarians employed in neuropsychiatric and tuberculosis hospitals was held April 25-29 at the VA Hospital,

Downey, Illinois, under the sponsorship of the Veterans Administration. The meeting was attended by professional medical librarians from VA hospitals throughout the country and from State hospitals in the area. It was under the direction of Mrs. Margaret T. Doran, Chief of the Medical Record Library Division, VA Central Office, assisted by Miss Margaret Kilduff, RRL, Downey VA Hospital.

The sessions were devoted largely to workshop discussion of particular problems and to the exchange of ideas. A few papers were presented, however. Dr. Lee G. Sewall, manager of the host hospital, spoke on "Professional Audit in a Neuropsychiatric Hospital"; Mrs. Doran and Dr. A. E. Maniscalco, Chief of Professional Services at Downey, reviewed the A. P. A. Standards for Psychiatric Hospitals and Clinics; Miss Mary Rose, RRL, of the Los Angeles VA Center, explained and demonstrated the use of the marginal punch card, and Mr. Bernard Frank, Biostatistician of the VA Central office, explained the methodology of cohort analysis.

## Medico-Legal Problems Demonstrated in Mock Trial

Each year the State Bar Association in New Jersey prepares a mock trial involving medical compensation problems for some particular County Bar Association. The purpose of these trials is to demonstrate to members of the legal and medical professions the proper way to interrogate a medical witness on compensation problems. A trial judge presides and lawyers representing both sides of the case interrogate and cross-examine two medical witnesses. Errors in the testimony are promptly pointed out for the benefit of members of both professions.

Recently Dr. Robert E. Bennett, Assistant Medical Director of the Trenton State Hospital and Dr. Robert S. Garber, Superintendent of the N. J. Neuro-Psychiatric Institute, took part in such a trial. This problem involved multiple sclerosis in a work injury and the question involved was whether the injury had precipitated the attack or was simply

incidental. Drs. Bennett and Garber found the experience a valuable one.

## Ash Trays Made From Unusable Plastic Trays

The Pre-Industrial Department of Stockton (Calif.) State Hospital is converting damaged food trays into ash trays. The food trays are made of heavy plastic which resists burning. The various-shaped food compartments are cut away from the framework and their edges trimmed smooth, to become ash trays. Mr. Lester Clark, the hospital's Assistant Superintendent for Business Services, says that each food tray usually yields five ash trays. The ash trays are given free of charge, through the Commissary, to any ward or department which requests them.

## Metal Patterns Used In Tailor Shop

The tailor shop at Polk (Pa.) State School uses patterns made of sheet metal for cutting out slippers, coats and trousers. The metal patterns, which were the idea of Mrs. Jessie Horrobin, tailoress in the shop, have several advantages over paper patterns. They stay firm on the material, eliminating pinning, and do not wear out.

The metal patterns are made up in the school's tin shop. Each has a hole drilled in it so it can be stored on wall pegs in the tailor shop, and has the size stenciled on it. A similar idea is used for cutting out scalloped curtain valances, but this pattern is made of plywood.

## Skid-Preventing Tape Makes Bathing Safer

The Modesto (Calif.) State Hospital has found several uses for the mineral-coated tape known as "Safety-Walk", made by the Minnesota Mining and Manufacturing Company. Used in bathtubs and showers, it is an excellent preventative of slipping, and after several months use has shown no signs of loosening or deterioration. Mr. J. J. Garvey, the Assistant Superintendent for Business Services, says that the tape can also be put to good use on running boards of trucks, kitchen or scullery floors, or any other place where dampness might cause skidding.

## People & Places

Dr. Paul H. Hoch has been appointed Commissioner of Mental Hygiene for New York State . . . Dr. Paul Haun has relinquished his teaching post at Winston-Salem to join the Eastern Pennsylvania Psychiatric Institute, Philadelphia, now under construction . . . Dr. G. Ronald Hargreaves has resigned from World Health Organization and heads the Department of Psychiatry at Leeds University, England. . . . Dr. Howard P. Morgan, formerly Chief, Professional Services, VAH, Roanoke, Va. becomes Manager, VAH, Fort Lyon, Colo. . . . Dr. Amerigo P. Dell Cort, formerly Chief of Professional Services, VAH, Lexington, Ky. is now Manager of the same hospital. . . . Dr. Thomas A. Harris, formerly at the N.P. Dept. U.S. Naval Hospital, Oakland, Calif. becomes Director of the newly formed Department of Institutions in the state of Washington; included in this department are the Divisions of Mental Health, Children and Youth Serv-

ice, Adult Corrections and Veterans Homes. . . . Dr. Howard T. Fiedler, formerly superintendent of the State Hospital at Retreat, Pa. has become superintendent of Allentown State Hospital, Pa. . . . Dr. Arthur O. Hecker, formerly of Friends Hospital, Philadelphia, is now superintendent of Embreeville State Hospital, Pa.; Dr. Jess V. Cohn, former superintendent, is now in private practice in Florida. . . . Dr. Lowell O. Dillon, Commissioner of the Division of Mental Hygiene, Columbus, Ohio, has resigned this position to carry on special studies in California. . . . Dr. George E. Peatick, formerly assistant superintendent of Philadelphia State Hospital, was named superintendent of Somerset (Pa.) State Hospital . . . Dr. Henry Luidens succeeded Dr. Hugo Mella as manager of the Coatesville (Pa.) VA Hospital . . . Dr. Maurice E. Linden, who directed the Gerontological Study Center at Norristown (Pa.) State Hospital, was appointed director of the mental health division of the Philadelphia Health Departments. . . . In Ohio, Dr. Roger M. Gove, formerly superintendent of

the Columbus State School and an assistant commissioner in the Division of Mental Hygiene, was named superintendent of the Juvenile Diagnostic Center in Columbus. His post at the school was assumed by Dr. Wendell A. Butcher. Other recent appointments include that of Dr. Conrad O. Ranger, formerly assistant superintendent of Norwich (Conn.) State Hospital, to be superintendent of the new Rollman Receiving Hospital in Cincinnati. He also was made an assistant commissioner in the Ohio Division of Mental Hygiene. . . . Dr. James T. Shelton became superintendent of California's Porterville State Hospital (for mental defectives), following the resignation of Dr. Charles Ludwig. Dr. Shelton served as Assistant Superintendent of Porterville since its opening in June, 1953. . . . Dr. William H. Wood was appointed Clinical Director of the Norways Foundation Hospital, Indianapolis, Ind. . . . Dr. Hyman Pleasure was named to succeed Dr. Walter A. Schmitz as director of Middletown (N.Y.) State Homeopathic Hospital. Dr. Schmitz has retired after serving 41 years on the staff of the hospital.

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# Occupational Therapy for the Mentally Deficient

By RUSSELL ANDERSON, B.S., O.T.R. and HARRY WATKINS, B.S., O.T.R.

Polk (Pa.) State School

**W**ORKING with the mentally defective has much to offer an occupational therapist. The wide variety of physical, emotional and intellectual disabilities found in mentally defective persons, along with divergences in chronological and mental age levels, make this a truly challenging endeavor. Almost all the techniques occupational therapy has developed can be used, yet the lack of published information as to which techniques are applicable to which types of patients points up the great opportunity for developing new programs.

## Concept of Rehabilitation

Much of the emphasis in occupational therapy with mental defectives is on helping the patient adjust to long-range hospitalization. For most of the patients, the more severely retarded, rehabilitation is in terms of increasing the patient's self-sufficiency within the institution rather than of preparing him for return to community life. This concept of rehabilitation, while seemingly limited in view of the term's fullest implications, is most meaningful when contrasted to the days when occupational therapy was more occupation than therapy . . . "busy work," in other words. Too often occupational therapy was a means of producing articles the hospital needed or could sell outside, and patients who could not produce usable or salable items were eliminated from the program. The supervisor of such a group usually was skilled in crafts but unprepared to deal with the physical or emotional needs of the patient.

Today's registered occupational therapist is trained to carry out a medically prescribed treatment program that will "assist the patient in his physical, mental, social and economic adjustment and rehabilitation."

## Adapted Activities Advisable

There is a relatively high percentage of physically disabled patients in

institutions for the mentally defective, most of whom are cerebral palsy cases, and the occupational therapist must be prepared to adapt activities to their disablements. It has been found that many of the O.T. activities used in rehabilitating the physically handicapped of normal intelligence are suitable for mentally retarded with physical disabilities. In the lower age groups, including patients with cerebral palsy and those whose retarded motor development has limited the muscular activity, the prevention of skeletal deformities and muscular weakness must be considered in planning their O.T. program. For older patients, the objective would be helping them attain a higher level of functioning within the limits of their physical and mental capacities.

In working with brain-injured children without physical handicaps the occupational therapist's objective is to help them overcome their particular drawbacks so that they can realize their fullest mental potentialities. Strauss' book on the "Psychopathology and Education of the Brain-Injured Child" offers theories and methods designed to alleviate the perceptual, thinking and behavior disorders. Some neurological and psychological orientation is necessary to appreciate and understand such techniques. Since this is related to the training of an occupational therapist, it offers an interesting area of experimentation and development.

## Emotional Problems Helped

The occupational therapist in the institution for mental defectives must be prepared also to deal with emotional problems. Only a small percentage of patients are diagnosed as psychotic, but there are a number of patients who have situational difficulties from time to time and the new admissions usually present adjustment problems. Here occupational therapy can help by giving them opportunities

for self-expression on a non-verbal level.

Activities for nursery-grade patients should be structured to awaken interests, develop basic perception and provide muscle action. Thus the program would be designed to help prevent inactivity, apathy, and physical deterioration. The program should also help prepare the child to receive training for daily living. By reaching the child as soon as possible, with a preparatory program of this type, many might be saved from becoming strictly custodial cases.

## Developing Vocational Growth

As the retarded child develops at his limited rate, he eventually reaches a point where his needs are no longer specific, but fall into more general areas of development, such as social and vocational growth. This is particularly true of children who have reached their educational limits but who are not physically mature enough to participate in a hospital industry program. The occupational therapist can present a graded program of work activities which can be brought to a group of patients, as opposed to an individual being assigned to a specific job. Almost all types of outdoor or indoor work usually done by patients could be included, such as housecleaning tasks, sorting jobs and seasonal work. When necessary, the group could be taken to the job source. The emphasis would be, of course, on the patient's development of work tolerance and good work habits, rather than on the job itself. The supervisor of such a group must carefully demonstrate and explain the work, then closely direct the job. This is an excellent opportunity for the therapist to observe the work habits of each patient in the group, and to gauge his readiness to enter the Industrial Therapy program.

Occupational therapists in such a setting, working as it were in a virtu-

ally uncharted area of the profession, must, perhaps, possess an extra spark of ingenuity, a bit more patience, than their colleagues in other settings. They will, however, be rewarded, for although mentally retarded patients generally lack insight, their eagerness and appreciation more than make up for it. They will reap also, in terms of professional growth, the rewards inherent in developing this relatively new area of occupational therapy.

It must be emphasized that occupational therapy is not a program that can function efficiently by itself. It is only one of several adjunctive therapies. As such, for maximum patient benefit, occupational therapy should be coordinated with the other therapies, training programs and services, and should be under the direction of a physician versed in the potentialities of an occupational therapy program.

## Ideas from Polk's O.T. Dept.



**Above:** A shadow-board ensures that all tools are put back in their proper place after use. To the left, medicine jars, their tops nailed to the undersides of storage shelves, make handy containers for small O.T. supplies, such as nails and beads. Each jar is labeled and numbered, and a corresponding number applied to the shelf edge, so that patients can easily find and replace the supply jars. These innovations are found in the storage section of the divided office-storage units in Polk's O.T. classrooms. The units were created by partitioning off a 12 by 8 foot corner of the rooms with masonite panels.



**Above:** Simplified workbooks were devised by Miss Betty Campbell, a psychologist who teaches brain-injured children at Polk. Since these children are easily distracted, Miss Campbell (shown here with a pupil) revised the regular elementary workbooks to eliminate all distracting features, such as page numbers. The figures were traced onto stencils, run off on white paper and glue-bound into tablets by the Print Shop.

The simplified books have fewer objects per page than the commercial books, and increase in complexity more gradually. The children are started on a book containing simple geometric figures and pictures of familiar objects. They color the objects (all triangles the same color, etc.), identify, count and discuss them. Miss Campbell then introduces them to abstract numbers in a second book, following with simple addition problems using the object symbols. The third book has addition problems using abstract numbers.

The children who complete all three workbooks are able to start using simple commercial workbooks.

**Below:** These younger patients enjoy working at the Activity Board, where they can draw, paste up or use the pegboard panel. The plywood Activity Boards were made in the school's shop, using Better Homes and Gardens Handy Plan No. 115.



## Psychiatrists & Writers Discuss Joint Problems

An unusual conference was held at Swampscott, Mass. from June 24th through 26th to enable psychiatrists and mass communications specialists to explore some of the difficulties which exist in establishing good public relations for psychiatry. Besides medical men, the conference was attended by editors of national magazines and of magazine medical departments, popular magazine writers, newspaper science reporters and editors, television executives, a newspaper editor, a newspaper publisher and public and press relations specialists.

The conference was unusual because it attempted to formulate no conclusions nor plan any immediate future action. It was educational in the broadest sense of the word. Ideas and opinions were freely exchanged without any attempt to do more than learn, in a friendly and cooperative atmosphere, something of the difficulties faced both by psychiatry and the mass media professions in usefully communicating psychiatric subject matter to the general public. The

meeting, the first of its kind, was planned as a first step toward more profitable and satisfactory relationships between the medical profession—specifically psychiatry—and the communications professions in their difficult, mutual task.

About 60 delegates attended the conference, which was supported jointly by The Ittelson Family Foundation, The Albert and Mary Lasker Foundation, The Division Fund and The Harris Foundation. It was held under the auspices of The American Psychiatric Association, The National Association of Science Writers and The Niemann Foundation for Journalism. The A.P.A. Committee on Public Information was directly responsible for arrangements and Dr. Wilfred Bloomberg was Chairman of the Conference. Other members of the Program Committee were Dr. Daniel Blain; Mr. Alton Blakeslee, Science Editor of the Associated Press; Mr. Albert Deutsch; Dr. Henry Laughlin; Mr. Louis Lyons, Curator, The Niemann Foundation for Journalism; Dr. Rob-

ert T. Morse, Chairman of the A.P.A. Committee on Public Information and Mr. Robert L. Robinson.

For convenience, the discussion material was arranged under five different headings:

1. The review and discussion of existing objective data and empirical observations concerning public attitudes about psychiatry and the implications of such attitudes.
2. Special characteristics of psychiatric subject matter that prevent or inhibit its useful communication to the public, and the implications of these characteristics for informing the public about psychiatry.
3. Specific difficulties of working together encountered by editors, writers and other public communications specialists on the one hand and by psychiatrists on the other.
4. Contributions to the formulation of a policy statement for the guidance of the profession of psychiatry and for the individual psychiatrist working with the press and other public communications specialists.
5. Psychiatry's problems in the field of public relations.

Special presentations were given by Miss Shirley Star, Senior Study Director of the National Opinion Research Center, University of Chicago; Dr. John Spiegel, Department of Social Relations, Harvard University, and Mr. Irving Harris, the Harris Foundation, Chicago.

A report of the conference is in preparation, and will be published and distributed within the next few months. It is expected to be of considerable value and interest to all concerned with communicating psychiatric and other medical subject matter to the public.

### THE THIRD ANNUAL PSYCHIATRIC INSTITUTE

On September 21, 1955 the New Jersey Neuro-Psychiatric Institute at Princeton, New Jersey, will hold its Third Annual Psychiatric Institute.

This year the program will be devoted exclusively to the residential care of psychiatric disorders in children. Among the speakers will be R. Finley Gayle, Jr., M.D., President of A.P.A.; Frederick H. Allen, M.D., Director of the Philadelphia Child Guidance Clinic; Othilda Krug, M.D., Director of the Child Guidance Home, Cincinnati; Rene A. Spitz, M.D., who is in private practice in New York City; Eveleen N. Rexford, M.D., Director of the Douglas A. Thom Clinic for Children, Boston; Sally Ann Provence, M.D., Assistant Professor of Pediatrics, Child Study Center of Yale University; Mr. Joseph H. Reid, Executive Director of the Child Welfare League of America; and John A. Rose, M.D., Supervising Psychiatrist at the Philadelphia Child Guidance Clinic; Dean Wayne Vasey of Rutgers University School of Social Service and John Flumerfeldt, M.D. of University Hospitals, Cleveland. John W. Tramburg, recently appointed Commissioner of the New Jersey Department of Institutions and Agencies, will preside at the evening meeting.

The program last year attracted between 700 and 800 visitors. In view of the outstanding program on a very timely subject, the Institute expects an even larger attendance for this coming program. Information concerning registration can be obtained by writing to Robert S. Garber, M.D., Superintendent.

### Back Issues Still Needed

*In order to complete our sets of bound volumes of MENTAL HOSPITALS, several copies of the October 1950 and April 1951 issues are still needed. If you have any spare copies of either or both of these issues, Mental Hospital Service would greatly appreciate receiving them.*

*Our heartfelt thanks is extended to the readers who supplied us with the back issues requested in the June MENTAL HOSPITALS. We regret that it was not possible to acknowledge each contribution individually.*

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